

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Buchanan Place		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Buchanan Rd New Tazewell, TN 37825	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to submit a Pre-admission Screening and Resident Review (PASRR) timely after a new mental health diagnosis for 2 residents (Resident #4 and Resident #79) of 11 residents reviewed for PASRR. The findings include: Review of the facility's PASRR (Preadmission Screening and Resident Review) Policy, undated, revealed .The facility shall ensure .Timely identification of residents requiring Resident Review due to significant changes in status .Level I Screening .Initial screening performed prior to admission or when a significant change in status occurs . Review of a Level 1 PASRR dated 6/30/2025 (prior to admission), revealed Resident #4 had diagnoses of Anxiety Disorder and Mild or Situational Depression. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder and Major Depressive Disorder. Continued review revealed the resident received a new mental health diagnosis of Psychotic Disorder with Delusions on 7/4/2025. Review of the comprehensive care plan revised 5/13/2026, revealed Resident #4 had a care plan for Major Depressive Disorder, Anxiety Disorder, and Psychotic/Delusional Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 had active diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder. Review of the medical record revealed a new PASRR for Resident #4 had not been submitted for the new diagnoses of Major Depressive Disorder and Psychotic Disorder with Delusions. Review of a Level I PASRR dated 7/27/2021 (prior to admission), revealed Resident #79 had diagnoses of Schizophrenia, Schizoaffective Disorder, Major Depression, Psychotic/Delusional Disorder, Bipolar Disorder, Personality Disorder, Anxiety Disorder, Mild or Situational Depression, and Other Mental Health Diagnosis (Malingering). Review of the medical record revealed Resident #79 was admitted to the facility on [DATE] with a diagnosis of Post Traumatic Stress Disorder (PTSD). Review of the comprehensive care plan revised 1/21/2025, revealed Resident #79 had a care plan for PTSD. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #79 had an active diagnosis of PTSD. Review of the medical record revealed a new PASRR for Resident #79 had not been submitted for the diagnosis of PTSD. During an interview on 6/23/2026 at 1:51 PM, the Director of Nursing (DON) stated a new Level I PASRR should be submitted with any new major mental health diagnosis. The DON confirmed that Resident #4 and Resident #79 did not have a new Level I PASRR submitted after a new mental health diagnosis was identified.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations and interviews, the facility failed to obtain a Physician's Order for 1 resident (Resident #26) of 2 residents reviewed for Continuous Positive Airway Pressure (C-PAP) use. The findings include: Review of the facility's policy titled, Physician Services, dated 4/2013, revealed .Physician orders .shall be maintained in accordance with current .regulations and facility policy . Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses to include Obstructive Sleep Apnea and Shortness of Breath. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #26 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident had a diagnosis of Obstructive Sleep Apnea. Review of the Physician Orders dated 6/23/2026, revealed Resident #26 did not have an order for the use of a C-PAP machine.During an observation and interview on 6/23/2026 at 10:53 AM, in Resident #26's room, revealed the C-PAP machine on the bedside nightstand. Further interview revealed the resident had used a C-PAP for over 15 years and had admitted to the facility with the C-PAP. During an observation on 6/23/2026 at 11:15 AM, in Resident #26's room, revealed Resident #26 sitting in his wheelchair at bedside. On the bedside nightstand a C-PAP machine was observed. During an observation on 6/23/2026 at 1:14 PM, in Resident #26's room, revealed on the bedside nightstand a C-PAP machine was observed. During an interview on 6/23/2026 at 1:17 PM, Licensed Practical Nurse (LPN) A confirmed Resident #26 did not have an order for the use of a C-PAP machine. During an observation and interview on 6/23/2026 at 1:44 PM, The Assistant Director of Nursing confirmed Resident #26 did not have a physician's order for the use of a C-PAP machine.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility staff failed to perform appropriate hand hygiene when serving residents' meal service for 4 residents (Residents #75, # 74, #78, and #6) in 1 of 2 dining areas observed for meal tray distribution, and failed to ensure C-PAP equipment was kept in a clean and sanitary condition for 1 resident (Resident #26) of 2 residents reviewed for C-PAP. The Findings include: Review of the facility's policy titled, Assisting the Resident with In-Room Meals, revised 12/2013, revealed .Employees must wash their hands before serving food to residents .employee must wash his/her hands before serving food to the next resident . Review of the facility's policy titled, Hand Washing, revised 5/17/2016, revealed .The facility considers hand hygiene .primary means to prevent .spread of infections . Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus (DM), and Depression. Review of the quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #75 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #75 required Setup or clean-up assistance with eating and partial/moderate assistance with Activities of Daily Living (ADLs). Review of the comprehensive care plan dated 5/24/2026, revealed Resident #75 .Requires assistance with ADLs r/t [related to] self-care deficit .d/t [due to] .DM COPD . During an observation on 6/22/2026 at 12:07 PM, the Activities Director (AD) delivered the lunch meal tray to Resident #75. The AD set up the meal tray for Resident #75 and failed to offer the resident hand hygiene and the AD failed to sanitize her hands after serving the tray. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Adult Failure to Thrive, Diabetes Mellitus, Dementia, and Need for Assistance with Personal Care. Review of the quarterly MDS assessment dated [DATE], revealed Resident #74 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident required supervision or touching assistance with eating and partial/moderate assistance with ADLS. Review of the comprehensive care plan dated 5/18/2026, revealed Resident #74 .Requires assistance with ADL's .impaired cognition .need for assistance with personal care .Staff to assist with completion of ADL's on .daily basis . During an observation on 6/22/2026 at 12:10 PM, the AD delivered the lunch meal tray to Resident #74. The AD set up the tray for Resident #74 and failed to offer hand hygiene to the resident and the AD failed to sanitize her hands after serving the tray. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #78 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Resident #78 required supervision or touching assistance with eating and partial/moderate assistance with personal hygiene. Review of the comprehensive care plan for Resident #78, dated 6/10/2026, revealed .Requires assistance with ADL's r/t .self care deficit .d/t .Dementia .COPD . During an observation on 6/22/2026 at 12:11 PM, AD delivered the lunch meal tray to Resident #78. AD set up tray for Resident #78 and failed to offer hand hygiene for the resident before assisting with the lunch meal and AD failed to sanitize her hands after serving the tray. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Anxiety, Depression, and Need for Assistance with Personal Care. Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #6 required supervision or touching assistance with eating and dependent with personal hygiene. Review of the comprehensive care plan for Resident #6, dated 4/30/2026, revealed .Requires assistance with ADL's r/t self-care deficit .staff to assist with completion of ADL's on a daily basis . During an observation on 6/22/2026 at 12:13 PM, the AD delivered the lunch meal tray to Resident #6. The AD set up tray for Resident #6 and failed to offer hand hygiene for the resident before assisting with the lunch meal and the AD failed to sanitize her hands after serving the tray. During an interview on 6/22/2026 at 12:15 PM, the AD confirmed that she had not offered hand hygiene while passing the meal service trays to Residents #75, #74, #78, and #6 and had failed to sanitize her hands after passing the lunch meal trays to Residents #75, #74, #78, and #6. During an interview on 6/23/2026 at 2:44 PM the Infection Preventionist (IP) confirmed that it was her expectation that staff offer hand hygiene to residents when serving meal trays, and that staff sanitize hands between each meal tray. During an interview on 6/24/2026 at 8:28 AM, the Director of Nursing (DON) stated it was the facility's expectations hand hygiene was to be offered to residents prior to meals and staff sanitize hands after passing each resident's meal tray. Review of the facility's policy titled, CPAP/BIPAP, [continuous positive airway pressure/bilevel positive airway pressure] dated 3/2026, revealed .Each resident receives necessary care and services .in accordance with professional standards of practice . Review of the facility's policy titled, CPAP/BIPAP Support/Maintenance, dated 3/2015, revealed .General Guidelines for Cleaning .Masks .and tubing .Clean daily by placing in warm, soapy water and soaking for 5 minutes .Rinse with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	warm water .air dry . Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including Obstructive Sleep Apnea and Shortness of Breath. Review of a quarterly MDS assessment dated [DATE], revealed Resident #26 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident had a diagnosis of Obstructive Sleep Apnea. During an observation and interview on 6/23/2026 at 10:53 AM, in Resident #26's room, revealed a C-PAP machine positioned on the nightstand. The C-PAP tubing and mask were resting on the mattress of the bed. The mask had a brown substance caked on the inside of the mask. The resident stated he did not know when the mask had last been cleaned. Further interview revealed the resident had used a C-PAP for over 15 years and had admitted to the facility with the C-PAP. During an observation on 6/23/2026 at 11:15 AM, in Resident #26's room, revealed Resident #26 sitting in his wheelchair at bedside. On the nightstand was a C-PAP machine with the tubing under a pillow and mask exposed on the mattress. The inside lining of the mask was caked with a brown substance. During an observation on 6/23/2026 at 1:14 PM, in Resident #26's room, revealed a C-PAP on the bedside nightstand. The tubing and mask were resting on the mattress of the bed. The mask had a brown substance caked on the inside of the mask. During an interview on 6/23/2026 at 1:17 PM, in Resident #26's room. Licensed Practical Nurse (LPN) A, confirmed the mask was dirty with a brown substance and could not indicate when the mask was last cleaned. During an observation and interview on 6/23/2026 at 1:44 PM, in Resident #26's room, The Assistant Director of Nursing (ADON) confirmed the C-PAP mask was dirty and had a caked on brown substance on the inside of the mask and stated, .the mask definitely needs to be cleaned . The ADON confirmed the expectation was for the C-PAP mask to be clean, sanitary, and free of debris for resident use.		